STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155478	A. BUILDING _____ B. WING _____	03/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF JASPER	2909 HOWARD DRIVE JASPER, IN47546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 03/10/11 Facility Number: 000314 Provider Number: 155478 AIM Number: 100274210 Surveyor: Lex Brashear, Life Safety Code Specialist At this Life Safety Code survey, Waters of Jasper was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire	K0000	Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has a capacity of 76 and had a census of 65 at the time of this survey. Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 03/11/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0052 SS=F	Based on record review and interview, the facility failed to ensure documentation for the testing of all smoke detectors was correct. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires fire alarm system devices such as smoke detectors be tested annually. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on review of the facility's quarterly fire alarm system inspection reports in the red inspections book on 03/10/11 at 9:20 a.m. with the Maintenance Director present, the two most recent semiannual fire alarm system inspection reports dated 01/07/11 and 07/09/10 both indicated on the cover page and the itemized list of devices the facility was provided with forty one Photo type smoke detectors, however, the most recent smoke detector sensitivity test report dated 02/24/10 indicated the facility was provided with only	K0052	It is the facility's intent to have the fire alarm system tested and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. Actions to be taken: The Maintenance Director contacted the licensed contractor immediately following survey. The contractor completed a visual review and count of the smoke detectors in the facility on 3/11/11. Along with each smoke detector being numbered to correlate with the paperwork. The contractor has corrected and submitted to the facility required paperwork for smoke detectors. How are others identified: No other smoke detectors were identified. Measures taken to correct: The Maintenance Director will place the number of smoke detectors on the preventative maintenance program for schedule of review with contractors. At any time a new smoke detector is installed the program will be updated to reflect. The Maintenance Director will review paperwork with contractor on completion of inspection to ensure the correct number of smoke detectors were tested and inspected.	03/11/2011

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	forty smoke detectors, of which thirty eight were Ion type smoke detectors and two were Photo type smoke detectors. During interview at the time of record review, the Maintenance Director indicated one smoke detector was added in the facility's fire alarm panel room since the sensitivity test was performed on 02/24/10, however, that particular smoke detector was not identified on the two most recent semiannual fire alarm system inspection reports. 3-1.19(b)		How will it be monitored: The Administrator/Designee will review inspection report for accuracy of smoke detectors. The Administrator/Designee will review audits in quarterly QA meeting with Medical Director. This Plan of Correction constitutes our credible allegation of compliance with all regulatory requirements, our date of completion is: 03/11/11	